

**CLAIM FOR COMPARABLE COVERAGE**

Pursuant to K.S.A. 39-708c(g)

Name of Claimant: \_\_\_\_\_

Date: \_\_\_\_\_

Address of Claimant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

SSN: \_\_\_\_\_

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**DEPENDENTS:**

Name	Address	Date of Birth:	Relation to You:
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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**DCF OFFICE INFORMATION:**

Name of DCF Service Center: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of DCF case worker handling public assistance and/or employment service case: \_\_\_\_\_

\_\_\_\_\_

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**INJURY INFORMATION:**

Name of employer/worksites  
where injury occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_

Place of accident or injury: \_\_\_\_\_

What the claimant was doing when injured: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List circumstances about how the accident occurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**COMPENSATION INFORMATION:**

Types of benefits or public assistance received or other compensation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Amount of claim or type of compensation requested: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medical expenses have been paid

by: \_\_\_\_\_

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**Basic Information Relating to Claims for Comparable Coverage**

1. K.S.A. 39-708c includes the provision that the Secretary of DCF shall provide protection to Work Experience and Community Service participants under the Workers Compensation Act or shall provide comparable coverage if the individual is injured while working at a work site. (DCF has elected to provide comparable coverage.)
2. Claims for benefits must be filed within 30 (thirty) days of the accident or injury.
3. The Director of Economic and Employment Services will review the claim- A decision about the claim will be made within (30) thirty days.
4. Decision regarding the amount of benefits will be based upon K.S.A. 44-511 (b)(6)(B) and any other applicable statute within the Workers Compensation Act, K.S.A. 44-501, et seq.
5. The claimant will be notified by mail of the decision. Instructions about how to file a request for administrative hearing will be included in the decision notification.

Send the completed form to:

Director of Economic and Employment Services  
Docking State Office Building, Room 581 -W  
915 S.W. Harrison  
Topeka, Kansas 66612